CHUBB®

Western Claim Service Center
P.O. Box 42065
Phoenix, AZ 85080
O (925) 598-6000
F (623) 308-3481

March 21, 2019

Farber & Co
333 Hegenberger Road, Suite 504
Oakland, CA 94621

MAR 25 2019

Re:

Employee:	Jonathan Shockley
Employer:	Biotelemetry, Inc
D/Injury:	2/15/2019
Policy No.:	000071738154/000090
Claim No.:	040519008736
Company:	Chubb Indemnity Insurance Company

In accordance with the Rules of Practice and Procedures of the Workers' Compensation Appeals Board, we submit the following:

(X) Medicals as follows: All Medicals received from 3/5/19 to 3/21/19

- Patrick O. Lang,M.D.,dated: 3/5/19

Very truly yours,

Mario Castro
Claims Examiner

PROOF OF SERVICE
1013A (3) CCP

STATE OF CALIFORNIA, COUNTY OF CONTRA COSTA

I am employed in the County of Contra Costa, State of California. I am over the age of 18 and not a party to the within action. My business address is 2603 Camino Ramon, Suite 300, San Ramon, CA 94583-9136.

On March 21, 2019, I served the foregoing document described as medical record on the interested parties in this action by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at San Ramon, California addressed as follows:

AA/Farber & Co
333 Hegenberger Road, Suite 504
Oakland, CA 94621

Executed on March 21, 2019 in San Ramon, California.

I declare under penalty of perjury, under the laws of the State of California that the above is true and correct.

Signature

Timothy Bluitt
Typed or Printed Name

The Hand Center of San Francisco, Inc

Kyle D Bickel, MD **Patrick O Lang, MD**

Hand and Wrist Surgery Upper Extremity Reconstruction Microsurgery Reconstructive Surgery

2019-03-01

Chubb/Wc
Po Box 42065
Phoenix, AZ 85080

RE:	Jonathan Shockley
Employer:	Biotelemetry
DOI:	02/16/2019
Claim #:	7173815490

HAND SURGERY CONSULTATION

Dear Ladies and Gentlemen:

I saw this patient today for evaluation of his bilateral hand, wrist, and forearm pain. Thank you for the referral.

HISTORY OF INJURY This patient is a 40-year-old right-hand-dominant electrocardiogram technician who reports a several month history of worsening bilateral hand, wrist, and forearm pain. He reports that his job requires very intense and prolonged use of a computer and mouse. The symptoms arose in the setting of at work. He does not recall any other specific history of trauma.

CURRENT SUBJECTIVE COMPLAINTS The patient reports vague and diffuse bilateral hand, wrist, and forearm pain.

PREVIOUS WORK/INJURY HISTORY The patient reports a prior Achilles tendon injury.

PAST MEDICAL HISTORY Patient denies any significant past medical history. Surgical history includes removal of a bone spur from the foot and two prior Achilles tendon operations. Medications include aspirin and Advil as needed. He has no known drug allergies.

SOCIAL HISTORY The patient works as an electrocardiogram technician but does extensive data analysis on a computer. He previously worked as a ballet dancer. He does not smoke. He does not drink alcohol.

601 Van Ness Ave Suite 2018 San Francisco CA 94102
Tel: 415.751.HAND (4263) Fax: 415.359.1925 email admin@sfhand.com
www.sfhand.com

Patient Name Shockley, Jonathan
Date of Visit 2019-03-01
Page **2** of **2**

PHYSICAL EXAM Vital signs SPO2 100%, blood pressure 116/59, heart rate 61, respiratory 12, temperature 96.7.

Examination of the bilateral upper extremities reveals no deformity. Tinel's sign in the ulnar nerve at the elbow is negative bilaterally. Forearm compartments are soft and nontender to palpation bilaterally. Finkelstein's test is negative bilaterally. Watson's test is negative bilaterally. Wrist and digital range of motion are normal bilaterally. There is no A1 pulley tenderness or triggering throughout either hand. Sensation is grossly intact distally bilaterally.

IMPRESSION 40-year-old man with bilateral upper extremity repetitive strain injury.

TREATMENT RECOMMENDATIONS I had a lengthy discussion with the patient regarding his diagnosis of repetitive strain injury. The symptoms are undoubtedly related to his work on a computer. I recommended he begin working with an occupational hand therapist on a repetitive strain protocol. I also talked with him about optimizing his computer workstation ergonomics and using dictation software is much as possible. All questions are answered. I can see him back in 6-8 weeks to reassess his symptoms.

Thank you again for the referral. Please let me know if I can be of any further help.

Sincerely,

Patrick O Lang, M.D.
Cal Lic #A106890
POL/ja
ELECTRONICALLY SIGNED BY PATRICK O LANG, MD

Executed at San Francisco, CA. Date: 3/5/2019 6:42:42 AM
I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated California Labor Code 139.3

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Tel: 415.751.HAND (4263) Fax: 415.359.1925 email admin@sfhand.com
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The Hand Center of San Francisco, Inc

Kyle D Bickel, MD **Patrick O Lang, MD**

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State of California, Division of Workers' Compensation
REQUEST FOR AUTHORIZATION
DWC Form RFA

Attach the Doctor's First Report of Occupational Injury or Illness, Form DLSR 5021, a Treating Physician's Progress Report, DWC Form PR-2, or equivalent narrative report substantiating the requested treatment.

X New Request □ Resubmission – Change in Material Facts
□ Expedited Review: Check box if employee faces an imminent and serious threat to his or her health
□ Check box if request is a written confirmation of a prior oral request.

Employee Information

Name (Last, First, Middle): Jonathan Shockley		
Date of Injury (MM/DD/YYYY): 02/16/2019	Date of Birth (MM/DD/YYYY): 1978-09-27	
Claim Number: 7173815490	Employer: Biotelemetry	

Requesting Physician Information

Name: Patrick O Lang, MD		
Practice Name: The Hand Center of San Francisco	Contact Name: Kim	
Address: 601 Van Ness Ave. #2018	City: San Francisco	State: CA
Zip Code: 94102	Phone: 415-751-4263	Fax Number: 415-359-1925
Specialty: Hand Surgery	NPI Number: 1194966416	
E-mail Address: admin@sfhand.com		

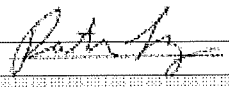
Claims Administrator Information

Company Name: CHUBB/WC	Contact Name: Maria Neish	
Address: PO BOX 42065	City: PHOENIX	State: AZ
Zip Code: 85080	Phone: 925-598-6030	Fax Number: 213-612-5785
E-mail Address:		

Requested Treatment (see instructions for guidance; attached additional pages if necessary)

List each specific requested medical services, goods, or items in the below space or indicate the specific page number(s) of the attached medical report on which the requested treatment can be found. Up to five (5) procedures may be entered; list additional requests on a separate sheet if the space below is insufficient.

Diagnosis (Required)	ICD-Code (Required)	Service/Good Requested (Required)	CPT/HCPCS Code (If known)	Other Information: (Frequency, Duration Quantity, etc.)
Bilateral RSI	M79.641	Hand Therapy, Evaluation and treatment	97003, 97530, 97110, 97112	2x per week, for 6 weeks, total of 12 visits Facility: Golden Gate Hand Therapy TIN: 54-2192724 fax 415-447-3868 ph 415-359-1444

Requesting Physician Signature:  Date:3/5/19

Claims Administrator/Utilization Review Organization (URO) Response

Authorization Number (if assigned):		Date:	
Authorized Agent Name:		Signature:	
Phone:	Fax Number:	E-mail Address:	
Comments:			

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☐ Kyle D Bickel, MD
☒ Patrick O Lang, MD

HAND THERAPY PRESCRIPTION

Patient: Shockley, Jonathan Date: 3/1/19

Diagnosis: Bilateral RSI

Date of Onset/Surgery: ___/___/___

Treatment: _____

Splinting: R/L: _____

Treatments/Modalities: RSI protocol

☐ ROM
☐ Active
☐ Passive

☐ Edema Control
☐ Wound Care
☐ Massage

☐ Ultrasound
☐ Iontopheresis
☐ Warm/Cold
☐ Icing
☐ Paraffin Bath
☐ Other _____

☐ Scar/Soft Tissue
☐ Myofascial

☐ Flexor Tendon Rehabilitation
☐ Duran
☐ Kleinert

☐ Extensor Tendon Rehabilitation
☐ Nerve Gliding Exercises. Nerve: _____
☐ Desensitization
☐ Sensory Re-Education
☐ Strengthening
☐ Sensory Testing/Mapping
☐ Home Exercise Program (HEP)

Precautions/Restriction: _____

Frequency: 1 - 3 5 x per week, for 6 weeks.

Signature: _____